PRIMARY CARE

FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report:

The mission of the Bureau of Primary Health Care (BPHC) is to increase access to primary and preventive care and to improve the health status of underserved and vulnerable populations. BPHC seeks to meet its mission through the development and support of systems and providers of high quality, community based, culturally competent care. There is mounting evidence that access to a usual and regular source of such care can reduce and even eliminate health status disparities among subsets of the Nation's population. Targeted populations include the uninsured, underinsured, underserved, low income, women and children, homeless persons, migrant farm workers and people in frontier and rural areas. Through its programs, BPHC assists communities in addressing the needs of these populations, who are particularly at risk for poor health outcomes, and builds broader primary care capacity through partnerships with States and localities. Over 11 million of the Nation's neediest people receive care through BPHC programs emphasizing prevention, early detection and timely intervention in approximately 4000 communities.

Programs included in this section are:

2.1 Health Centers and the National Health Service Corps
2.2 Black Lung Clinics
2.3 National Hansen's Disease Program
2.4 Nursing Education Loan Repayment
2.5 Federal Occupational Health Program

FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report:

2.1 Program Title: Health Centers and the National Health Service Corps

Performance Goals	Targets	Actual Performance	Refer-ence
I. ELIMINATE BARRIERS TO CARE **A. Increase Utilization** 1. Increase the number of uninsured and underserved persons served by Health Centers, with emphasis on areas with high proportions of uninsured children to help implement the SCHIP program.	FY 01: 9.7M FY 00: 9.6M FY 99: 8.9M	FY 01: FY 00: FY 99: 5/00 (9.15M est.) FY 98: 8.7M FY 97: 8.3M	B101
B. Increase Access Points 1. Increase the field strength of the National Health Service Corps through scholarships and loan repayment agreements.	**Field** / **Unduplicated Users** FY 01: 2,691 / 2.3M FY 00: 2,697 / 2.3M FY 99: 2,526 / 2.1M	**Field** / **Unduplicated Users** FY 01: FY 00: FY 99: (5/00) FY 98: 2,439 / 2.0M	B121
2. Increase the percent of NHSC clinicians retained in service to the underserved	FY 01: 75% FY 00: 74% FY 99: 72%	FY 01: FY 00: FY 99: (5/00) FY 98: 70.4%	B121
C. Focus on Target Population 1. Assure access to preventive and primary care for low income individuals (i.e., at or below 200 % of poverty).	**Unduplicated Users** **HC NHSC** FY 01: 86% 8.26M 2.0M FY 00: 86% 8.26M 2.0M FY 99: 86% 7.65M 1.8M	FY 01: FY 00: FY 99: 5/00(HC&NHSC) FY 98: 86% (UDS/HC) FY 97: 86% (UDS/HC)	B101

Performance Goals	Targets	Actual Performance	Refer-ence
2. Assure access to preventive and primary care for minority individuals (racial minorities or of Hispanic origin).	**Unduplicated Users** **HC NHSC** FY 01: 65% 6.24M 1.5M FY 00: 65% 6.24M 1.5M FY 99: 65% 5.79M 1.4M	FY 01: FY 00: FY 99: 5/00(HC&NHSC) FY 98: 64% (UDS/HC) FY 97: 65% (UDS/HC)	B101
3. Assure access to preventive and primary care for uninsured individuals.	**Unduplicated Users** **HC NHSC** FY 01: 45% 4.37M 1.0M FY 00: 43% 4.10M .99M FY 99: 42% 3.80M .88M	FY 01: FY 00: FY 99: (5/00) FY 98: 41% 3.52M FY 97: 39% (HC)	B101
II. ELIMINATE HEALTH DISPARITIES **A. Utilization of Services** 1. Increase percent of users with diabetes with up-to-date testing of glycohemoglobin **B** % adults with diabetes tested at recommend intervals	FY 01: 90% FY 00: 80% FY 99: 60%* *Diabetes initiative at 90% for first 100 HCs	FY 01: FY 00: FY 99: 6/00 FY 98: 43% **Norm**: 20%	B101
2. Increase percent of users with diabetes who have had an annual dilated eye exam (New goal for FY 2001)	**HP** **BPHC** FY 10: 70% FY 01: 90% FY 00: 70% FY 00: 80% FY 99: 70%	FY 01: FY 00: FY 99: 6/00 FY 94: 57% FY 89: 49%	B101 HP-17

Performance Goals	Targets	Actual Performance	Refer-ence
3. Increase proportion of health center women receiving age-appropriate screening for cervical and breast cancer. a) Up-to-date PAP tests b) Up-to-date mammograms c) Up-to-date clinical breast exams	**HP** **BPHC** FY 10: 85% FY 01: 94% FY 00: 85% FY 00: 92% FY 99: 90% FY 10: 60% FY 01: 70% FY 00: 60% FY 00: 67.5% FY 99: 65% FY 10: 60% FY 01: 85.5% FY 00: 60% FY 00: 84% FY 99: 82.5%	FY 01: FY 00: 4/01 FY 99: 5/00 FY 95: 88.5% FY 01: FY 00: 4/01 FY 99: 5/00 FY 95: 62.5% FY 01: FY 00: 4/01 FY 99: 5/00 FY 95: 80.5%	B101 HP-16
4. Increase proportion of Health Center adults with hypertension who report their blood pressure is under control.	**HP** **BPHC** FY 10: 50% FY 01: 96% FY 00: 50% FY 00: 93% FY 99: 92%	FY 01: FY 00: 4/01 FY 99: 5/00 FY 95: 90%	B101 HP-15
III. ASSURE QUALITY OF CARE **A. Appropriateness of Care** 1. Decrease proportion of Health Center users who are hospitalized for potentially avoidable conditions.	FY 01: 13 FY 00: 13.5 FY 99: 14	FY 01: FY 00: FY 99: 9/01 FY 98: 9/00 FY 97: 14.7/1000 **Norm:** 18.9/1000	B101
Total Funding: Health Centers and the National Health Service Corps ($ in 000's)	FY 2001: $1,182,441 FY 2000: $1,132,507 FY 1999: $1,037,080 FY 1998: $ 940,064	B x: page # budget HP: Healthy People 2000 chapter	

2. 1. 1 Program Description, Content And Summary of Performance

Context/Performance:

Health Centers and the National Health Service Corps form a cost-effective, integrated safety net for underserved and uninsured children, adults, migrant workers, homeless individuals, public housing and U.S./Mexico border residents in approximately 4,000 communities across the country and will serve more than 11 million persons in fiscal year FY 2000 who would otherwise lack access to primary care clinicians. These 11 million persons represent about 10% of the nation's uninsured, 10% of its 33 million Medicaid recipients, and 20% of the 43 million underserved people in federally designated areas lacking access to primary care providers. This community-based network delivers preventive and primary care services for the neediest, poorest, and sickest patients in rural and inner city areas, through a Federal, State, and community partnership approach.

The high quality primary health care received in these programs reduces hospitalizations and emergency room use, reduces annual Medicaid costs, and helps prevent more expensive chronic disease and disability. Reductions in Medicaid costs range from 30 to 34%, according to a Health Center effectiveness study. Health Center Medicaid patients are 22% less likely to be inappropriately hospitalized than Medicaid beneficiaries who obtain care elsewhere. Patients at Health Centers have rates of hypertension and diabetes that far exceed national prevalence rates for comparable racial/ethnic and socioeconomic groups. Yet, Health Center diabetics are twice as likely to have their glycohemoglobin tests performed at regular intervals than national norms, and hypertensives are more than three times as likely to report that their blood pressure is under control. Health Centers have comparable rates of low birth weight deliveries as the U.S. in general despite their higher level of risk, and have reduced by 50% the persistent national gap in low-birth weight deliveries between African Americans and other racial/ethnic groups. Health Center women are far more likely to receive age-appropriate breast and cervical cancer screening, and their rates exceed the Healthy People 2010 goals. Health Center patients are far less likely to delay, postpone or not comply with treatment regimens than the Nation's poor and near poor. In fact, their level of unmet need is as low as the rate for middle and high income Americans. Having a usual and regular source of primary health care has been shown to have as much of an effect on health status disparities as income inequality. Apparently, Health Center patients are far more likely to have a usual and regular source of care than poor people of color in the Nation, which bodes well for eventual reductions and eliminations of their health status disparities.

Performance goals for the Health Centers and NHSC relate to reduction of disparities and increases in access. The conditions selected for the President's Initiative on Race provide a context for the disparity reduction goals. Health Centers and the NHSC contribute to decreases in racial and income disparities for these conditions by providing preventive services and risk reduction to a population that is largely minority (64%) and low income (86%) and disproportionately uninsured (41%). About 75% of patients are uninsured or on Medicaid which makes these sites extremely vulnerable to the market-driven downward pressure on revenues.

Specific performance indicators in this area include breast and cervical cancer screening, content of diabetic care, control of hypertension and decreases in potentially avoidable hospitalizations. Hypertension and diabetes are the most prevalent chronic conditions among Health Center users. Monitoring performance in chronic disease management for these conditions will serve as a marker for the quality of care delivered at Health Centers and sites and ultimately measure their ability to eliminate health disparities within the population served. In addition, breast and cervical cancer screening are effective measures for reducing future morbidity and mortality particularly among poor, minority, uninsured individuals. Performance here will serve as a marker for the quality of preventive care delivered and measure Health Center and site ability to reduce or eliminate disparities in early detection of disease for this population. Finally, tracking avoidable hospitalizations is a measure of access to care. Poor people of racial/ethnic minorities who are uninsured are more likely to postpone or avoid obtaining needed care which often results in more expensive hospitalizations. Avoiding these hospitalizations not only contains costs, but it indicates that such individuals consider their provider as a regular and usual source of care. Providing such care to the most vulnerable has been shown to eliminate their health disparities.

Specific performance indicators in the access area include the number of persons served by Health Centers, the field strength of the NHSC, which provides a culturally competent workforce for health centers and other sites who otherwise find it difficult to recruit clinicians on their own, and continued assurance of preventive and primary care services to low income, minority, and uninsured individuals.

Tracking individual Health Center and site performance on these measures will enable the program to continuously improve its overall level of performance. Successful strategies employed in Health Centers and sites with rates that far exceed the average can be shared with Centers and sites that could use improvement in their rates. Continuously monitoring and improving the quality of care will result in overall Program performance that moves toward the proposed targets.

Program-level Data Issues:

Data Issues in Determining Unmet Need for Primary Care

BPHC has been working for several years to improve the ways in which underserved areas are identified and the unmet need for primary care is quantified. Information on these areas, known as Medically Underserved Areas/Populations(MUA/Ps) and Health Professional Shortage Areas (HPSAs) underlies the performance goals for increasing access to primary care through Health Centers and the National Health Service Corps. New regulations have been developed with input from States, affected organizations, and the academic community. The new regulations were published in the Federal Register on September 1, 1998 publication as a Notice of Proposed Rulemaking. They respond to criticism from GAO by: combining the two previously separate methods, thereby reducing burden and providing periodic updating of MUA/Ps as well as HPSAs; including J-1 visa waiver physicians and nurse practitioners, certified nurse midwives, and physician assistants in counts of primary care providers; using research-proven proxies for health status; and proactively providing validated national data to designation applicants.

BPHC has received over 800 comments on the proposed regulations. It intends to revise these regulations to take into consideration these comments, conduct new impact analyses, and then develop a new proposed rule for comment. BPHC has acquired detailed physician data and plans to acquire detailed nurse practitioner, certified nurse midwife, and physician assistant data to conduct these analyses.

Discussion of Data Sources

In order to prepare for the implementation of GPRA, several years ago BPHC initiated a three-part data and evaluation strategy. First, a Uniform Data System (UDS) was developed and implemented to collect aggregate administrative, demographic, financial, and utilization data annually from each organization receiving support. This system, which combined five previously separate reporting formats, is in its fourth year of operation for 694 health center grantees and is being phased in for NHSC sites. It is validated through edit checks and onsite reviews conducted during each organization's project period. It is used to supply information for the performance goals related to access.

Second, surveys of a representative sample of health center users and provider visits were developed in collaboration with the National Center for Health Statistics. These surveys provide in-depth information on individuals and the care they receive, based on and comparable to the National Health Interview Survey (NHIS) and the National Hospital Ambulatory Medical Care Survey, (NHAMCS), respectively. The national surveys are the source of most Healthy People 2000 and 2010 objectives, which can then be used as targets for BPHC performance goals related to disparity reduction. Information from the health center User and Visit Surveys fielded in 1995 are used for baselines; BPHC plans to repeat these surveys in 2000 and at five year intervals thereafter to provide longitudinal comparisons for GPRA. In cases where BPHC performance has met or exceeded national targets, individual Program-specific targets have been established.

Third, BPHC reoriented its portfolio of other evaluation efforts, shifting from a descriptive case-study approach to the use of previously validated secondary data sources that enable a comparison of users and similar populations of non-users, and systematic sampling of organizations and users. Notable among these efforts are studies of Community Health Center Effectiveness, that use claims data from HCFA's State Medicaid Research Files (SMRF) and on-site reviews of content of care, and Hospitalizations for Ambulatory Care Sensitive Conditions, which also uses the SMRF files to examine potentially avoidable hospitalizations. As with the surveys, information from them will be used for performance goals related to disparity reduction, although some additional work is needed to develop appropriate targets and baselines. Efforts are underway to extract the information needed for follow up measures on an ongoing basis.

BPHC also plans to develop a data gathering infrastructure that will assure that performance measures are gathered annually through special studies. It will develop teams of data gathers at sentinel sites to obtain outcomes data on an annual reporting basis. Ultimately, BPHC will work to develop the data and tracking infrastructures within service delivery sites (Chronic Disease Collaborative: Diabetes, Asthma,

Hypertension) to assure prompt annual reporting on the performance measures and obtain health status outcome measures.

2.1.2 Goal-by-Goal Presentation of Performance

Goal I.A.1: Increase the number of uninsured and underserved persons served by Health Centers, with emphasis on areas with high proportions of uninsured children in order to help implement the State Child Health Insurance Program.

Context:

Health Centers play an essential role in the Nation's safety net, providing preventive and primary care to nearly 20% of the 43 million underserved people in federally designated underserved areas lacking access to primary care providers.

Indicator: Total number of clients served in underserved areas.

Performance:

In 1998, according to data retrieved from the Bureau's Uniform Data System (UDS), 694 Health Centers served 8.67 million people in 35 million encounters at a average cost per user of about $369 dollars. Approximately 41% of users are under the age of 19, and over 1.2 million of those children are uninsured. Grant dollars represent 26% of Health Center revenues. Medicaid revenues have dropped from 35% to 34% in 1998 while uninsured users have increased to 41%, placing additional reliance upon the Federal grant dollars. It is estimated that 9.7 million people will be served by the Centers in 2001. In addition, the number and percent of uninsured users served will continue to increase (see Goal I.C.3. below).

Goal I. B. 1: Increase the field strength of the National Health Services Corps through scholarships and loan repayment agreements.

Context:

The NHSC clinicians provide additional access to care for underserved people beyond that achieved by the Health Centers. About 60% of these clinicians are located in other practices in underserved areas.

Indicators: Total size of NHSC field strength, total unduplicated users, and total users.

Performance:

Currently, NHSC field strength is 2,526 serving approximately 3 million people. According to recent NHSC data, approximately 40% of NHSC clinicians serve in grant-supported sites whose users are counted above. The number of unduplicated users at NHSC non-grant-funded sites is estimated at about

2 million. The percentage of NHSC clinicians in grant-funded sites is anticipated to drop to 35% by 2001, continuing the 2.5% per year decline experienced in the last four years. There are a number of possible explanations for this decline: 1) Health Centers have become more attractive places to work, making recruitment of clinicians without obligations easier; 2) Higher NHSC retention rates result in less turnover and fewer vacancies; and 3) NHSC efforts to reach out to more unserved communities increases the total number of communities where NHSC clinicians are practicing which reduces the Health Center share while holding the number of NHSC clinicians in Health Centers at current levels.

	FY 1998 Actual	FY 1999	FY 2000 Appropriation	FY 2001
Scholarship Obligers	533	648	894	894
Federal Loan Repayers	1,306	1,282	1,323	1,323
Careerists	64	52	42	42
Obligated Feds	6	8	8	8
State Loan Repayers	508	518	414	414
Community Scholars	22	18	16	10
Total Field Strength	2,439	2,526	2,697	2,691

The NHSC will begin to collect UDS data from non-grant sites this year so that user data and other information will be available by May 2000.

Goal I. B. 2: Increase the percent of NHSC clinicians retained in service to the underserved.

Context:
Retention of NHSC clinicians preserves access to care for the underserved beyond the period of service commitment.

Indicator: Percent of NHSC clinicians who remain in service to the underserved one-year following completion of their service commitment. NHSC will provide these figures in the Annual Retention Reports.

Performance:
According to the NHSC 1998 Annual Retention Report, 70.4% of NHSC clinicians report remaining in service to the underserved at an interview conducted after completion of service commitment. This percentage has grown steadily from the mid 50% since 1995. Program evaluation study indicates that 60% of NHSC clinicians who completed their service commitments between 1983 and 1997 are currently in

service to the underserved. The Program plans to measure retention at one year and follow cohorts of clinicians over their working lives to assess retention at longer intervals.

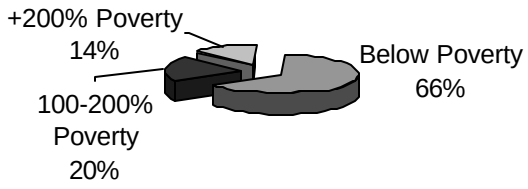
Goal I.C.1. Continue to assure access to preventive and primary care for low income individuals.

Context:
To eliminate health disparities, safety-net programs must target access to care for people of racial/ethnic minority groups, of low income, and who are uninsured.

Indicator: Proportion of Health Center and NHSC patients below 200 percent of poverty.

Performance:
According to UDS Health Center data, 86 percent of patient were at or below 200 percent of the Federal poverty level in FY 1998. This figure has remained constant for the three years for which UDS data have been collected.

86% of Those Served by Health Centers Are Low Income



With market pressures it will be a challenge for service delivery sites to remain serving such a percentage of people in poverty. It is currently estimated that the percentage of users at or below 200 percent of poverty will increase. These actuals will come from annual UDS Health Center data for 1998-2001, but by May 2000 will include UDS NHSC data.

Goal I.C.2. Continue to assure access to preventive and primary care for minority individuals.

Context:
To eliminate health disparities, safety-net programs must target access to care for people of racial/ethnic

minority groups, of low income, and who are uninsured.
Indicator: Proportion of Health Center and NHSC clientele that are underserved minorities.

Performance:
According to UDS Health Center data, in FY 1998 the population served included 26 percent African American, 34 percent Hispanic, and 4 percent Asian/Other.

With market pressures it will be a challenge for service delivery sites to remain serving such a minority population. It is currently estimated that the percentage of minority users will increase. These estimates will come from annual UDS Health Center data for 1998-2001, but by May 2000 will include UDS NHSC data.

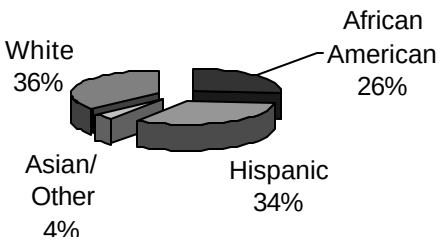
Goal I.C.3. Continue to assure access to preventive and primary care for uninsured individuals.

Context:
To eliminate health disparities, safety-net programs must target access to care for people of racial/ethnic minority groups, of low income, and who are uninsured.
Indicator: Proportion of Health Center and NHSC clientele that are uninsured.

Performance:
According to UDS Health Center data, in FY 1998 the population served included more than 3.52 million uninsured, which was 41% of the client population served. More than one-third or 1.2 million of the uninsured are children. In two of five Health Centers, the majority of patients are uninsured. About 75% of Health Center patients are either uninsured or Medicaid recipients. Recent research reveals that caseloads of private physicians in the primary care specialties include 10% uninsured and 9% Medicaid for a total of 19%. Primary care clinics in hospital outpatient departments include 12% uninsured and 38% Medicaid for a total of 50%. Another more recent report noted that private physicians' charity care averaged 10 hours per month for those who did not participate in managed care and less than 5 hours for those with 85% or more revenues attributed to managed care.

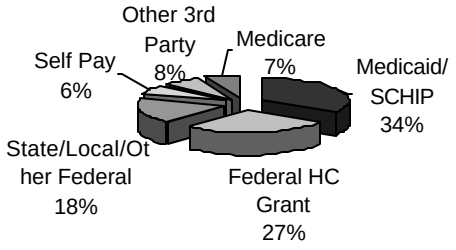
In addition, with market pressures increasing, it will be a challenge for service delivery sites to further

Two Thirds of Those Served by Health Centers Are People of Color

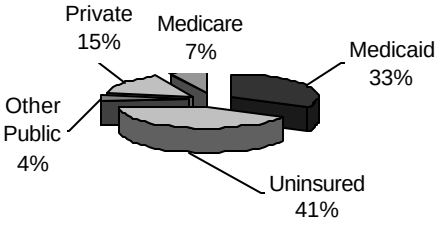


increase their role in serving such an uninsured population. Targets will be to assure that the percentage of uninsured who obtain services at BPHC sites will increase over current levels and that BPHC programs continue to serve as the safety-net providers for the Nation's uninsured, particularly those who are minorities and are at or below 200% of poverty. Uninsured Health Center users will increase by more than 200,000 between 1998 and 1999, and by an additional 300,000 each year through 2000 and 2001. The cost to Health Centers for a user to move from the roles of the insured to the uninsured is $220 per user. Should Medicaid revenue fail to continue to cover the costs of Medicaid Health Center users as a result of the phase-in of provisions of the Balanced Budget Act of 1997, fewer grant dollars will be available to subsidize the costs of the uninsured These estimates will come from annual UDS Health Center data for 1999-2001, but by May 2000 will include UDS NHSC data.

A Quarter of Health Center Revenues Come From Federal Health Center Grants



2 Out of 5 Served by Health Centers Are Uninsured

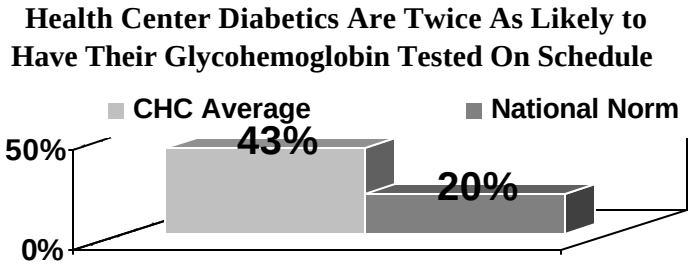


Goal II A. 1. Increase the proportion of users with diabetes with up-to-date testing of glycohemoglobin

Context:

Poor people of racial/ethnic minority groups and who are uninsured are more likely to suffer from chronic diseases such as hypertension and diabetes. Health Center users have unusually high rates of these chronic diseases. Clinical evidence indicates that access to appropriate care can improve the health status of people with these chronic diseases and thus reduce or eliminate their health status disparities. Managing the glycohemoglobin levels of diabetics and the blood pressures of hypertensives can have a pronounced effect on their morbidity and mortality.

Performance:



According to a Health Center Effectiveness Study conducted in FY 1997, 43% of adults with diabetes had up-to-date glycohemoglobin. Based on a literature survey conducted for the Health Center Effectiveness Study, 20 percent of adults with diabetes in mainstream medical practices had their glycohemoglobin tested at ADA- recommended intervals. Despite the fact that BPHC Program users have rates that are more than twice the national average, improvement goals will be 60%, 80%, and 90%, respectively. In the first year (by June 2000), the establishment of a measurement infrastructure under the Diabetes Collaborative will enable the 100 health centers participating to reach the 90% goal. BPHC has launched a special study of medical record review to assure annual estimates of up-to-date testing and to assess health status outcome for diabetic users.

Goal II A. 2. Increase percent of diabetic users who have had annual dilated eye exam.

Appropriate management of diabetes can have a significant effect on morbidity and mortality. Performance of regular eye exams can avoid serious limitations in functional capacity by preventing blindness in diabetics.

Performance:
In 1994, a Medicaid claims study of health center users revealed that 57% of adults with diabetes had a dilated eye exam within the past two years (Weiner, et al, JAMA, 1995).

Target FY 1999: 70%; 70%
Target FY 2000: 70%; 80%
Target FY 2001: 70%; 90%

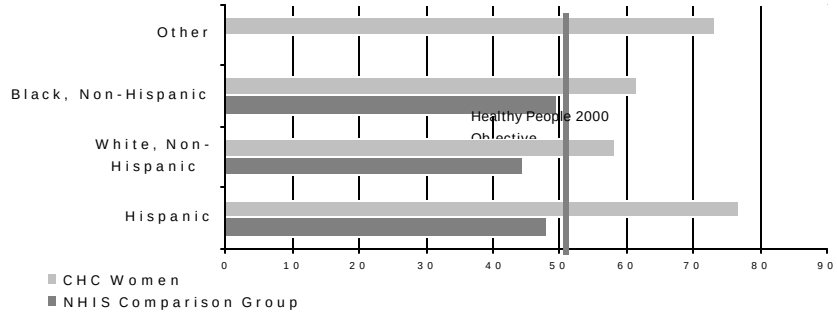
Healthy People 2000 includes the following objective for adults with diabetes: Increase to 70% the proportion of people with diabetes who have an annual dilated eye exam. According to a 1989 NHIS study, 49% in the general population had such an exam. For BPHC, their program targets are 70%, 80%, and 90% respectively, anticipating results from the Diabetes Collaborative by June 2000. Also, BPHC has launched a special study of medical records to assure annual estimates of dilated eye exams and to assess health status outcomes for diabetic users.

Goal II. A. 3 Increase the proportion of health center women receiving age-appropriate screening for cervical and breast cancer.

Context:
People of racial/ethnic minority groups, of low income, and who are uninsured have less access to appropriate screening and preventive services which results in their higher rates of morbidity and mortality. Access to these services can help to eliminate these health status disparities.

Performance:
The health center User Survey, comparable to the NHIS, showed the following results for health center women in 1995:

Health Center Women Exceed National Comparison and Healthy People 2000 Objectives For Up-to-Date Mammograms



Healthy People 2000 includes the following objectives for women generally, as measured by data from the National Health Interview Survey (NHIS):
1. At least 85 percent have up-to-date PAP Tests.
2. At least 60 percent have up-to-date mammograms.
3. At least 60 percent have up-to-date clinical breast examinations.

Health Center women reported being up-to-date on these examinations in higher proportions than did low-income women in the general population. Moreover, uninsured Health Center users are as up-to-date as users with insurance. In contrast to the general population, Health Centers have virtually eliminated the disparity in these indices among their users. In most cases, Health Center women met or exceeded the HP2000 objectives. Nevertheless, BPHC targets will be 90%, 92% and 94%, respectively, for up-to-date PAP tests, 65%, 67.5%, and 70% for up-to-date mammograms, and 82.5%, 84%, and 85.5% for up-to-date clinical breast exams.

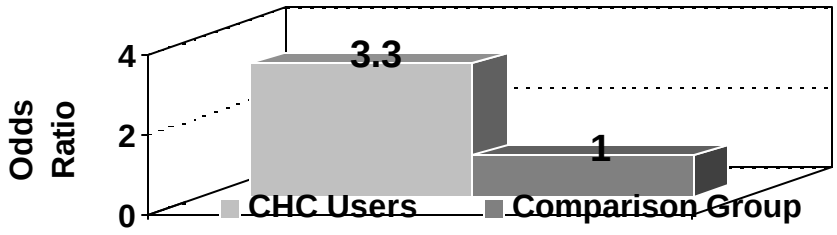
Follow-up: Plans to repeat the User Survey in 2000 will provide data in April 2001. To obtain annual reporting data, BPHC will launch a special study of medical records to obtain data by May 2000. This study also will track content of care to obtain estimates of health status.

Goal II. A. 4: Increase the proportion of Health Center adults with hypertension who report their blood pressure is under control.

Context:
Hypertension is the most prevalent chronic condition facing Health Center users. Clinical evidence indicates that controlling blood pressure can reduce morbidity and mortality.

Performance:
The health center User Survey, comparable to the NHIS, showed the following results for health center users in 1995: 90 percent report hypertension is under control.

African American & Hispanic Hypertensives Using Three Health Centers Are Times As Likely To Report Blood Pressure Under Control as NHIS Comparison Group



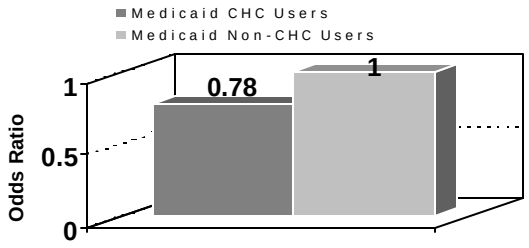
Healthy People 2000 includes the following objective for adults generally: At least 50 percent of people with hypertension report their blood pressure is under control. Despite the fact that BPHC Program users are more than three-times more likely to report blood pressure under control than a comparable national group, and that the current rate far exceeds the HP2000 objective, BPHC Program targets are 92%, 93%, and 96% respectively.

Plans to repeat the User Survey in 2000 will provide follow-up data in April 2001. BPHC has launched a special study of medical records to assure annual estimates of blood pressure control among hypertensive users and to assess health status outcomes for hypertensive users, with results by May 2000.

Goal III.A.1 Decrease the proportion of Health Center users who are hospitalized for potentially avoidable conditions.

Context:

Hospitalizations for potentially avoidable conditions, otherwise known as ambulatory care sensitive conditions (ACSC) are widely recognized as a measure of access to primary care. Reducing the rate of avoidable hospitalizations for people of racial/ethnic minority groups, of low income, and who are uninsured will help eliminate their health status disparities. Low rates indicate access to appropriate ambulatory services and is a measure of high quality of care delivered. It also indicates fewer access barriers that cause patients to postpone needed services, delay needed services, and fail to comply with treatment regimens.



Performance:

An ongoing evaluation comparing ACSC hospitalizations among Health Center Users and non-users using SMRF files plus review of data from the National Hospital Discharge Survey for the general population revealed 18.9 per 1000 ACSC hospitalizations among non-Health Center users compared to 14.7 for Health Center users. That is, Health Center Medicaid users are 22% less likely to be inappropriately hospitalized than Medicaid beneficiaries who use other providers.

Medicaid CHC Users Have Significantly Lower Odds of Being Hospitalized For An Ambulatory Care Hospitalization

To eliminate disparities, a target of 18.9/1000 would be appropriate. However, BPHC Program targets are 14, 13.5, and 13/1000, respectively, for FY 1999, 2000, and 2001 as Program should strive to eliminate virtually all avoidable hospitalizations. BPHC Program will share strategies for the reduction of avoidable hospitalizations with the Medicaid Program to help reduce such rates among other Medicaid beneficiaries. BPHC will have results from a follow-up ACSC study during 2000.

FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report:

2.2 Program Title: Black Lung Clinics

Performance Goals	Targets	Actual Performance	Refer-ence
I. ELIMINATE BARRIERS TO CARE **A. Increase Utilization for Underserved Populations** 1. Serve Black Lung clinic users with respiratory and pulmonary impairments, including provision of medical and non-medical services.	FY 01: 35,000 users FY 00: 35,000 FY 99: 35,000	FY 01: FY 00: FY 99: 6/00 FY 98: 35,000 users	B134
Total Funding: Black Lung Clinics ($ in 000's)	FY 2001:$ 5,943 FY 2000:$ 5,943 FY 1999:$ 4,998 FY 1998:$ 4,976	B x: page # budget HP: Healthy People goal	

2.2.1 Program Description, Context and Summary of Performance

Context/Performance:

The Black Lung program provides funding to public and private entities for the operation of clinics that provide diagnosis, treatment, and rehabilitation of active and retired coal miners with respiratory and pulmonary impairments. In addition to treatment of Black Lung disease and directly-related conditions, coverage includes prescription drugs, office visits, hospitalizations, and, with specific approval, durable medical equipment, outpatient pulmonary rehabilitation therapy, and home nursing visits. Since 1984, Black Lung beneficiaries have steadily declined. In FY 1984, approximately 100,000 primary beneficiaries filed almost 164,000 claims. Over time the number of beneficiaries will continue to decline.

2.2.2 Goal-by-Goal Presentation of Performance

Goal I.A.1: Serve Black Lung clinic users with respiratory and pulmonary impairments, including provision of medical and non-medical services.

Indicator: Number of individuals provided medical and non-medical services.
Data is collected from annual grantee reports.
Target: FY 1999:35,000 users
Target: FY 2000:35,000 users
Target: FY 2001:35,000 users

2.3 Program Title: National Hansen's Disease Program

Performance Goals	Targets	Actual Performance	Refer-ence
I. ELIMINATE BARRIERS TO CARE **A. Increase Utilization for Underserved Populations** 1. Provide residential care for the current HD residential patients at Carville.	FY 01: 45 patients FY 00: 52 FY 99: 80	FY 01: FY 00: FY 99: 60 FY 98: 125 patients	B129
2. Provide payment of assisted living allowances for those long-term residential patients willing and able to live independently.	FY 01: 57 patients FY 00: 59 FY 99: 46	FY 01: FY 00: FY 99: 60 patients FY 98: NA	B129
3. Continue to provide outpatient care for HD patients across the country	FY 01: 3000 patients FY 00: 3000 FY 99: 3000	FY 01: FY 00: FY 99: FY 98: 3000 patients	B129
Total Funding: National Hansen's Disease Program ($ in 000's)	FY 2001:$ 19,311 FY 2000:$ 22,337 FY 1999:$ 23,957 FY 1998:$ 21,886	B x: page # budget HP: Healthy People goal	

2.3.1 Program Description, Context and Summary of Performance

The Hansen's Disease program consists of the National Hansen's Disease program at Carville, Louisiana and other outpatient clinic locations in the continental United States and a direct payment to the State of Hawaii Department of Health. These activities provide or support treatment of Hansen's disease. The program also includes a research component at Louisiana State University. Funding for the renovation and modernization of buildings at the Center and the Payment to Hawaii is included in the total funding level.

HRSA is implementing legislation that relocates the National Hansen's Disease program from Carville, LA to Baton Rouge, and transfers ownership of the Carville facility to the State of Louisiana. The program has completed the move of core activities, including administration, research, clinical and skilled nursing care from the Carville facility. Some long term care functions will continue at the Carville facility.

2.3.2 Goal-by-Goal Presentation of Performance

Goal I.A.1. Provide residential care for the current HD residential patients at Carville.

Context:
As part of the legislation to restructure the operation of the Hansen's Disease Center in Carville, it was agreed that continuing care would be provided for those long term residents remaining at Carville.

Indicator: Extent to which residential care continues to be provided for the remaining residents. Data for this goal is provided by program managers.

Performance:
Baseline: FY 98:125 patients
Targets:
FY 99: 80 patients - Performance: 60 patients
FY 00: 52 patients* (Revised from 75 patients)
FY 01: 45 patients

The original estimate for FY 1999 was that 80 patients would be involved in this option. The actual performance for FY 99 was 60 patients due to a higher degree of acceptance of the option to receive an assisted living allowance and to live independently, as well as a group of 10-15 residents who require more intensive care and who have moved to Baton Rouge. Estimates for FY 2000 have also been revised from 75 to 52 patients to reflect this change in the base population.

Goal I.A.2. Provide payment of assisted living allowances for those long-term residential patients willing and able to live independently.

Context:
The legislation included in the 1998 appropriation included a provision to pay an assisted living allowance to resident patients who are capable of and elect to live independently. More patients agreed to this option than was originally estimated.
Indicator: Number of patient receiving the assisted living allowance
Data for this goal is provided by program managers.

Performance:
Targets:
FY 99: Patients receiving assisted living allowance: 60 patients
FY 00: Patients receiving assisted living allowances: 59 patients* (Revised from 50 patients)
FY 01: Patients receiving assisted living allowances: 57 patients

The original estimate for FY 1999 was that 46 patients would accept this option. The actual FY FY 99 performance was 60 patients due to patients receiving assisted living allowance and to live more independently. The estimates for FY 2000 and 2001 reflect this initial higher level of acceptance of stipends than originally projected.

Goal I.A.3: Continue to provide outpatient care for HD patients across the country.

Context:
The National Hansen's Disease Program includes a regional care program. The Hansen's Disease population in the U.S. approximates 6,000, of whom about 3,000 are cared for under the NHDP regional care program. Data is provided by program managers.

Indicator: Extent to which outpatient care is provided for HD patients

Performance:
Baseline: FY 98: 3,000 clients
Targets:
FY 99: 3,000 clients
FY 00: 3,000 clients
FY 01: 3,000 clients

2.4 Program Title: Nursing Education Loan Repayment Program

Performance Goals	Targets	Actual Performance	Refer-ence
I. ELIMINATE BARRIERS TO CARE **B. Increase Access Points** 1. Award nursing loan repayment contracts.	FY 01: 200 contracts FY 00: 200 contracts FY 99: 200 contracts	FY 01: FY 00: FY 99: 202 contracts FY 98: 170 contracts	B135
Total Funding: Nursing Loan Repayment Program ($ in 000's)	FY 2001:$ 2,279 FY 2000:$ 2,279 FY 1999:$ 2,278 FY 1998:$ 2,199	Bx: page # budget HP: Healthy People goal	

2.4.1 Program Description, Context and Summary of Performance

This program offers loan repayment to nurses in exchange for an agreement to serve not less than two years in an Indian Health Services center, in Native Hawaiian health center, in public hospital, in a health center, in rural health clinic, or in health facility determined by the Secretary to have a critical shortage of nurses. Achieving and maintaining adequate levels of nursing staff in shortage areas is the central purpose of the Nursing Education Loan Repayment Program. The program assists nurses by repaying up to 85 percent of their qualified educational loans in return for their commitment to be employed (or remain) at these health facilities.

2.4.2 Goal-by-Goal Presentation of Performance

Goal I.B.1. Award nursing loan repayment contracts.

FY 98: 170 loan repayment contracts
Targets:
FY 99: 200 loan repayment contracts - Performance: 202 contracts
FY 00: 200 loan repayment contracts
FY 01: 200 loan repayment contracts

Indicator: Number of Loan repayment contracts made

2.5 Program Title: Federal Occupational Health

Performance Goals	Targets	Actual Performance	Refe r- ence
I. ELIMINATE BARRIERS TO CARE **B. Increase Access Points** 1. Clinical Services: Provide needed basic clinical services to Federal employees.	FY 01: 227,000 served FY 00: 212,000 FY 99: 310,000	FY 01: FY 00: FY 99: 198,000 FY 98: 194,609 served	Off Budget
2. Environmental Health Services: Increase the number of specific environmental services provided.	FY 01: 35,300 services FY 00: 32,600 FY 99: 27,000	FY 01: FY 00: FY 99: (2/00) FY 98: 22,281 services	Off Budget
3. Employee Assistance Program: Provide needed employee assistance services.	FY 01: 1.3M FY 00: 1.3M FY 99: 1.241M	FY 01: FY 00: FY 99: (2/00) FY 98: 1.193M	Off Budget
III. ASSURE QUALITY OF CARE **C. Improve Customer/Patient Satisfaction** 1. Improve total customer satisfaction among Federal agencies served	FY 01: 95% satisfied FY 00: 95% satisfied FY 99: 90% satisfied	FY 01: FY 00: FY 99: (2/00) FY 98: 85% average satisfaction rate FY 97: 78% average satisfaction rate	Off Budget
Total Funding: Federal Occupational Health (Operating Level)	FY 2001:$90 million FY 2000: 86 million FY 1999: 83 million FY 1998: 83.146 million	B x: page # budget HP: Healthy People goal	

2.5.1 Program Description, Context and Summary of Performance

Context:

The Federal Occupational Health (FOH) program provides occupational health services and consultation to federal employees. The Public Health Services Act authorizes the heads of federal agencies to provide occupational health services to their employees. Ninety-nine Departments and agencies elect to do so by

entering into agreements with the Division of Federal Occupational Health (FOH) which is a part of the Department of Health and Human Services, Health Resources and Services Administration. The FOH program provides occupational health consultation and services to other federal agencies under Economy Act inter-agency agreements. Its over-all objective is to improve the health and safety of the federal workforce. The mission statement for FOH is: To become the benchmark for occupational health in the Nation. FOH's vision is:

> To be the provider of high-quality, cost-effective consultation and services that constitute a comprehensive approach, with a public health perspective, to improving the health and safety of the work force, through clinical, environmental, educational, and risk-based prevention programs.

Program-level Performance:
In FY 1998 FOH carried out 3,331 inter-agency agreements with 484 client federal agencies, who reimbursed FOH $83 million. Specifically:

- $39 million for basic clinical occupational health consultation and services for about 10 percent of the federal workforce, as well as for specialized clinical occupational health consultation and services. This included consultations with individual management officials and groups of managers, plus direct clinical services to individual employees and groups of employees.

- $9 million for environmental health services that benefit undefined numbers of employees in worksites where environmental problem are prevented or remediated

- $34 million for employee assistance programs available to over 1 million employees

The employee populations cited are not mutually exclusive. All told, FOH estimates that its programs directly benefit 1.3 million of the total 2.8 million federal employees.

2.5.2 Goal-by-Goal Presentation of Performance

Goal I.B.1: Clinical Services: Provide needed clinical services to Federal employees.

Context:
FOH provides clinical services to employees and consultation to management under two different types of inter-agency agreements: (1) walk-in service at permanent centers offering basic, comprehensive, nationally-standardized clinical services; and (2) specialized, on-demand-only clinical interventions wherever needed to help agency managers meet their specific occupational health responsibilities arising out of legislative and regulatory requirements or agency initiatives.

Performance:
In the baseline year of 1998, services were provided to approximately 195,000 employees. The FOH goal is to capture an ever-increasing share of the market for occupational health services to federal workers. There are not the usual resource restraints, since FOH is 100% reimbursable, and contract provider staff can be added as needed.

FY 99: 310,000
FY 00: 212,000* (Revised from 352,000)
FY 01: 227,000

*FY 00 target is based on actual FY 99 performance of 198,000 and inproved data sources. The actual performance level is stated in terms of the federal population covered by FOH clinical agreements for the basic, standard package of services that is sold at a per-capita, annual rate of $70 per eligible employee in the DC Metro area, and $89 per elsewhere. The data is available about 6 months into the fiscal year being reported on. However, FOH also sells agencies specialized fee-for-service clinical services and consultation, which equaled (in dollar sales) the basic clinical services in FY 1997, exceeded them by $2.5M in FY 1998, and might continue to widen the gap.

Projected levels are based on the volume of current business, a historical 95% renewal rate for clinical interagency agreements, marketing efforts, and trends such as agency budget pressures, competitors' successes, and downsizing.

Goal I.B.2: Environmental Health Services: Increase the number of specific environmental services provided.

Context:
Environmental health services enable customer federal agencies to comply with legislative and regulatory requirements for job safety/health and environmental matters. Methods include environmental and worker exposure monitoring, hazardous waste/materials management, safety audits, and training of employees and managers. These services meet the agency's need to create a safe workplace, and to identify, evaluate and control occupational health and environmental hazards to health. They protect employees, visitors, the general public, and the man-made and natural environment. They aid in the reduction of both work-related and non-work-related injury and illness.

Performance:
The baseline uses FY 1998 numbers of over 22,000 specific environmental services provided. This includes the number of safety inspections performed, indoor air quality studies done, etc. The data comes out of the FOH Management Information System. No interpretation is required. The data is available a few months after the close of the FY.

Projected levels are based on the volume of current business, marketing efforts, and trends such as agency budget pressures, competitors' successes, and downsizing.

FY 99: 27,000 services
FY 00: 32,600 services* (Revised from 29,000)
FY 01: 35,300 services
* Based on FY 99 data, a more current estimate for FY 00 is 32,600 services provided.

Goal I.B.3: Employee Assistance Program: Provide needed employee assistance programs.

Context:
Employee Assistance Programs provide consultation to supervisors regarding employee services (assessment of employee emotional, substance abuse, or situational problems that may interfere with job performance) and short term counseling for employees. Employees are more likely to be helped early in the course of an illness when confrontation and resolution occurs in the job setting, and when the source of help is close at hand and easy to access. This reduces the cost of treatment (including Federal benefits costs) and returns the employee to a more productive status sooner, thus minimizing productivity losses. Critical incident stress debriefing benefits groups of otherwise well employees who have just suffered trauma on the job. It helps them understand normal reactions to abnormal situations, and offers individual personal assistance when necessary.

Performance:
The baseline from FY 1998 is 1.193 million employees provided employee assistance services. In terms of determining actual levels, estimates are available approximately one quarter after the end of a fiscal year.

FY 99: 1.241 million served
FY 00: 1.3 million served
FY 01: 1.3 million served

Projected levels are based on the volume of current business, marketing efforts, and trends such as agency budget pressures, competitors' successes, and downsizing.

Goal III.C.1: Improve total customer satisfaction among Federal agencies served.

Context/Performance:
Customer satisfaction is measured by survey mechanisms. Fiscal year 1997 was the first year we systematically collected customer satisfaction data, so that data is the only baseline available. It showed a 78 percent satisfaction rate for federal agency occupational managers.

Data is available shortly after any given survey is done. A contractor interviews federal agency occupational health managers and other managers who are consumers of our services or consultation. The FY 1998 rating shown of 85 percent satisfaction is based on those interviews. It is somewhat expensive to have a contractor interview a large enough sample of managers to get valid numbers, so this may be done only every few years. In terms of future targets, the program reviews the last survey's numbers and estimates how much improvement can reasonably be accomplished.

Also, in 1998, we started using "how-did-we-do-today?" postcards to get satisfaction ratings from individual employees who used basic clinical services or visited an EAP counselor. Responses showed that 90 percent of users considered FOH services "excellent" and 9 percent considered them "good."